



General

Guideline Title

Breastfeeding the late preterm infant (34^{0/7} to 36^{6/7} weeks gestation).

Bibliographic Source(s)

Academy of Breastfeeding Medicine. ABM clinical protocol #10: breastfeeding the late preterm infant (34(0/7) to 36(6/7) weeks gestation). Breastfeed Med. 2011 Jun;6(3):151-6. [53 references] [PubMed](#)

Guideline Status

This is the current release of the guideline.

This guideline updates a previous version: Academy of Breastfeeding Medicine. Breastfeeding the near-term infant (35 to 37 weeks gestation). New Rochelle (NY): Academy of Breastfeeding Medicine; 2004 Aug 22. 6 p.

Recommendations

Major Recommendations

Definitions for the quality of evidence (I-III) are provided at the end of the "Major Recommendations" field.

Principles of Care

1. Communicate optimally:
 - a. Develop pathway and order set for breastfeeding the late preterm infant.
 - b. Communicate the discharge feeding plan clearly to the family and primary health provider.
 - c. Facilitate communication among physician, nurses, and lactation consultants in the inpatient and outpatient settings.
 - d. Avoid conflicting advice to mother and family about the feeding plan.
2. Assess/reassess:
 - a. Assess gestational age objectively and associated risk factors.
 - b. Observe closely for signs of physiologic instability.
 - c. Assess breastfeeding daily on the postpartum floor or special care nursery.
 - d. Assess breastfeeding issues carefully in the outpatient setting.
3. Provide timely lactation support in the inpatient and outpatient setting.
4. Avoid or minimize separation of mother and infant:
 - a. In the postpartum period, including immediately postpartum

- b. In cases in which either mother or infant is hospitalized for medical reasons
5. Prevent and promptly recognize frequently encountered problems in breastfed late preterm infants:
 - a. Hypoglycemia
 - b. Hypothermia
 - c. Hyperbilirubinemia
 - d. Dehydration or excessive weight loss
 - e. Failure to thrive
 6. Educate:
 - a. Educate staff and care providers in an ongoing manner on issues specific to breastfeeding the late preterm infant in the inpatient and outpatient settings.
 - b. Educate parents about breastfeeding the late preterm infant.
 - c. Train one (or two) outpatient office support person (RN or lactation educator) in:
 - i. Breastfeeding support, assessment, basic breastfeeding problem solving, and late preterm
 - ii. Breastfeeding issues
 7. Discharge/follow-up:
 - a. Develop criteria for discharge readiness.
 - b. Establish a post-discharge feeding plan.
 - c. Facilitate timely and frequent outpatient follow-up to assure effective breastfeeding after discharge.
 - d. Monitor carefully once the mother and late preterm infant are outpatients.
 8. Monitor care of the late preterm infant through quality improvement projects (in- and outpatient settings).

Inpatient: Implementation of Principles of Care

Quality of evidence for each recommendation, as defined in the U.S. Preventive Services Task Force guideline, is noted in parentheses (see definitions at the end of the "Major Recommendations" field).

These principles are guidelines for optimum care of the late preterm infant. Each provider and newborn unit should use these recommendations as applicable to their institution and practice.

1. Initial steps:
 - a. Communicate the feeding plan through a prewritten late preterm order set that can be easily modified (Hubbard, Stellwagen, & Wolf, 2007). (III)
 - b. Encourage immediate and extended skin-to-skin contact to improve postpartum stabilization of heart rate, respiratory effort, temperature control, metabolic stability, and early breastfeeding (Moore, Anderson, & Bergman, 2007). (I)
 - c. Assess gestational age by obstetrical estimate and Ballard/Dubowitz scoring (Ballard et al., 1991). (III)
 - d. Observe the infant closely for 12–24 hours to rule out physiologic instability (e.g., hypothermia, apnea, tachypnea, oxygen desaturation, hypoglycemia, poor feeding). As noted in the Background of this protocol (see the original guideline document), each delivery service must determine where and how this can best be accomplished while supporting the mother–infant dyad and breastfeeding. (III)
 - e. Encourage rooming-in 24 hours a day and frequent, extended periods of skin-to-skin contact. If the infant is physiologically stable and healthy, allow the infant to remain with the mother while receiving intravenous antibiotics or phototherapy (Gartner et al., 2005). (III)
 - f. Allow free access to the breast, encouraging initiation of breastfeeding within 1 hour after birth (Righard & Alade, 1990). (II-2)
 - g. Encourage breastfeeding ad libitum and on demand. Sometimes it may be necessary to wake the baby if he or she does not indicate hunger cues, which is not unusual in the late preterm infant (Walker, 2008). The infant should be breastfed (or breastmilk fed) eight to 12 times per 24-hour period. A mother may need to express her milk and give it to the baby using alternative feeding methods if the baby is not able to effectively breastfeed (Walker, 2008; Academy of Breastfeeding Medicine [ABM] Protocol Committee, 2009). (III)
 - h. Show the mother techniques to facilitate effective latch with careful attention to adequate support of the jaw and head (Thomas et al., 2007). (III)
2. Ongoing care:
 - a. Communicate daily changes in feeding plan either directly or with use of written bedside tool such as a crib card (Hubbard,

Stellwagen, & Wolf, 2007). (III)

- b. Evaluate desirably, within 24 hours of delivery, formally by a lactation consultant or other certified health professional with expertise in lactation management of the late preterm infant (Hubbard, Stellwagen, & Wolf, 2007). (III)
- c. Assess and document breastfeeding at least twice daily by two different providers using a standardized tool (e.g., LATCH Score [Jensen, Wallace, & Kelsay, 1994], Infant Breast-Feeding Assessment Tool [IBFAT] [Matthews, 1988], Mother/Baby Assessment Tool [Mulford, 1992]). (II-3)
- d. Educate the mother about breastfeeding her late preterm infant (e.g., position, latch, duration, early feeding cues, breast compressions, etc.) (Gartner et al., 2005; Walker, 2008). (III)
- e. Monitor vital signs, weight change, stool and urine output, and milk transfer (Neifert, 2001; "Breastfeeding," 2009). (III)
- f. Monitor for frequently occurring problems (e.g., hypoglycemia, hypothermia, poor feeding, hyperbilirubinemia) (Raja et al., 2006; Wight & Marinelli, 2006; Bhutani & Johnson, 2006). The late preterm infant should be followed closely with a low threshold for checking bilirubin levels and have a routine discharge bilirubin determination plotted on a Bhutani curve according to age in hours (American Academy of Pediatrics [AAP], Subcommittee on Hyperbilirubinemia, 2004; Maisels et al., 2009). (III)
- g. Avoid excessive weight loss or dehydration. Losses greater than 3% of birth weight by 24 hours of age or greater than 7% by day 3 merit further evaluation and monitoring (Hubbard, Stellwagen, & Wolf, 2007; Walker, 2008). (III)
 - i. If there is evidence of ineffective milk transfer, teach the mother to use breast compressions while the infant suckles (Walker, 2008) (III) and consider the use of an ultrathin silicone nipple shield (Meier, Furman & Degenhardt, 2007; Meier et al., 2000; Chertok, 2009). (II-2) The use of nipple shields is becoming more common for this group of infants and can be helpful. If a nipple shield is used, the mother and baby should be followed closely by a trained lactation consultant or knowledgeable healthcare professional. (III)
 - ii. Pre- and post-feeding weights may be helpful to assess milk transfer especially once lactogenesis II has occurred (Funkquist et al., 2010; Wilhelm et al., 2010; Scanlon et al., 2002; Meier et al., 1994). (II-2)
 - iii. The infant may need to be supplemented after breastfeeding with small quantities (5–10mL per feeding on day 1, 10–30mL per feeding thereafter) of the mother's expressed breastmilk, donor human milk, or formula (Hubbard, Stellwagen, & Wolf, 2007; ABM Protocol Committee, 2009). Mothers may supplement using a supplemental nursing device at the breast, cup feeds, finger feeds, syringe feeds, or bottle depending on the clinical situation and the mother's preference (ABM Protocol Committee, 2009). Cup feedings have demonstrated safety in preterm infants, although intake is less and duration of feeding is longer compared with bottle feeds (Marinelli, Burke, & Dodd, 2001; Howard et al., 2003; Collins et al., 2008). There is, however, little evidence about the safety or efficacy of other alternative feeding methods or their effect on breastfeeding. When cleanliness is suboptimal, cup feeding may be the best choice (United Nations Children's Fund, 1996). (I, II-1, II-2, II-3, III)
 - iv. If supplementing, the mother should pump or express milk after breastfeeding, six to eight times per 24 hours, until the baby is breastfeeding well to establish and maintain her milk supply (Neifert, 2001; ABM Protocol Committee, 2009). Use of a hospital-grade electric pump is recommended. Milk production may be increased by hand massage of the breasts while pumping (Morton et al., 2009). (II-3)
- h. Avoid thermal stress by using skin-to-skin (i.e., kangaroo) care (Moore, Anderson, & Bergman, 2007) (I) as much as possible or by double wrapping if necessary and by dressing the baby in a shirt and hat. Consider intermittent use of an incubator to maintain normothermia (Hubbard, Stellwagen, & Wolf, 2007; Walker, 2008). (III)

3. Discharge planning:

- a. Assess readiness for discharge, including physiologic stability and adequate intake exclusively at breast, or with supplemental feedings (AAP Committee on Fetus and Newborn, 2008). (II-2) The physiologically stable late preterm infant should be able to maintain body temperature for at least 24 hours in an open crib and have a normal respiratory rate, and weight should be no more than 7% below birth weight. Adequate intake should be documented by feeding volume or an improving pattern of infant weight (e.g., stable or increasing) (Hubbard, Stellwagen, & Wolf, 2007). (II-2) Twenty-four-hour test weights, with a scale designed for adequate precision may be useful to assess intake (Collins et al., 2008). (II-3)
- b. Develop a discharge feeding plan. Consider milk intake (mL/kg/day), method of feeding (breast, bottle, supplemental device, etc.), and type of feeding (i.e., breastmilk, donor human milk, or formula) (Hubbard, Stellwagen, & Wolf, 2007). If supplementing, determine method most acceptable to mother for use after discharge (ABM Protocol Committee, 2009). (III)
- c. Make an appointment for follow-up 1–2 days after discharge to recheck weight, feeding adequacy, and jaundice (Gartner et al., 2005). (II-2)
- d. Communicate discharge-feeding plan to mother and pediatric outpatient provider. Written communication is preferred. (III)

Outpatient: Implementation of Principles of Care

1. Initial visit:

- a. The first outpatient office or home health visit should occur 1 or 2 days after discharge (Gartner et al., 2005). (II-2)
- b. Review and place relevant information from the inpatient maternal and infant records, including prenatal, perinatal, infant, and feeding history (e.g., need for supplement in the hospital, problems with latch, need for phototherapy, etc.), in the outpatient chart. Gestational age and birth weight should be noted prominently ("Breastfeeding," 2009). (III)
- c. Review of breastfeeding since discharge by the physician needs to be very specific regarding frequency, approximate duration of feedings, and how the baby is being fed (e.g., at the breast, expressed breastmilk with supplemental device such as supplemental nursing system, finger feeds, or bottle with artificial nipple). Information about stool and urine output, color of stools, baby's state (e.g., crying, not satisfied after a feed, sleepy and difficult to keep awake at the breast during a feed, etc.) should be obtained. If the parents have a written feeding record, it should be reviewed (Neifert, 2001). (III)
- d. Examine the infant, including an accurate weight without clothes and calculation of percentage change in weight from birth, change in weight from discharge, state of alertness, and hydration. Assess for jaundice with transcutaneous bilirubin screening device and/or serum bilirubin determination if indicated (Neifert, 2001). (III)
- e. Assess the mother's breast for nipple shape, pain and trauma, engorgement, and mastitis. The mother's emotional status and degree of fatigue should be considered, especially when considering supplemental feeding routines. Whenever possible, observe the baby feeding at the breast, evaluating the latch, suck, and swallow (Neifert, 2001). (III)

2. Problem solving:

- a. Poor weight gain (<20g/day) is most likely the result of inadequate intake. Median daily weight gain of a healthy newborn is 28–34 g/day (Grummer-Strawn, Reinold, & Krebs, 2010). The healthcare provider must determine whether the problem is insufficient breastmilk production, inability of the infant to transfer enough milk, or a combination of both. The infant who is getting enough breastmilk should have at least six voids and four sizable yellow seedy stools daily by day 4, have lost no more than 7% of birth weight, and be satisfied after 20–30 minutes of nursing (Neifert, 2001). The following strategies may be helpful:
 - i. Shortening duration of breastfeeds if the late preterm infant is not satisfied after approximately 30 minutes
 - ii. Increasing the frequency of breastfeeds
 - iii. Supplementing (preferably with expressed breastmilk) after suckling or increasing the amount of supplement
 - iv. Instituting or increasing frequency of pumping or manual expression. Consider referral to a lactation specialist (III)
- b. For infants with latch difficulties, the baby's mouth should be examined for anatomical abnormalities (e.g., ankyloglossia [tongue-tie], cleft palate), and a digital suck exam should be performed. The mother's nipples and breast should be examined for plugged ducts, mastitis, engorgement, fullness of the breast, and nipple trauma. The infant should be observed breastfeeding to examine the latch, suck, swallow. A referral to a trained professional lactation specialist or in the case of ankyloglossia a referral to a healthcare provider trained in frenotomy may be indicated (Neifert, 2001; Hogan, Westcott, & Griffiths, 2005; Geddes et al., 2008; Ballard, Auer, & Khoury, 2002). (I, II-2, III)
- c. The jaundiced late preterm infant poses more of a problem when considering management of hyperbilirubinemia. All risk factors should be determined, and if the principal factor is lack of milk, the primary treatment is to provide more milk to the baby, preferably through improved breastfeeding or expressed breastmilk supplementation. If home or institution based phototherapy is indicated, breastmilk production and intake should not be compromised (AAP Subcommittee on Hyperbilirubinemia, 2004; ABM Protocol Committee, 2010). If the mother's own milk or donor milk is not available, small amounts of cow's milk-based formulas can be used (ABM Protocol Committee, 2010). Hydrolyzed casein formulas should be considered for this purpose, as there is evidence that they are more effective in lowering serum bilirubin than standard infant formula (Gourley et al., 1999). (II, III)
- d. Consider the use of a galactagogue (a medicine or herb that increases breastmilk supply) in mothers who have a documented low breastmilk supply and for whom other efforts to increase milk production have failed (Gabay, 2002; ABM Protocol Committee, 2011). (II-2, III)
- e. The mother's ability to cope and manage the feeding plan should be evaluated. If the mother is not coping well, work with her to find help and or modify the feeding plan to something that is more manageable (ABM Protocol Committee, 2009). (III)

3. Follow-up:

- a. Babies who are not gaining well and for whom adjustments are being made to the feeding plan may need a visit 2–4 days after each adjustment. A home health provider preferably trained in medical evaluation of the newborn and in lactation support, who reports the weight to the primary care provider, could make this visit. (III)
- b. All infants, including late preterm breastfed infants, should receive vitamin K shortly after birth ("AAP Vitamin K Ad Hoc Task Force," 1993) (II-3) and vitamin D supplementation (400 IU/day) beginning in the first few days of life as recommended by the American Academy of Pediatrics (Wagner et al., 2008). (II-3) Late preterm breastfed infants are at risk for iron deficiency as their iron stores are less than that of the full-term infant (Berglund, Westrup, & Domellöf, 2010). (I) The American Academy of Pediatrics Committee on Nutrition recommends 2 mg/kg/day of elemental iron for all preterm infants from 1 to 12 months of age. The late preterm breastfed infant will, therefore, need 2 mg/kg/day of iron supplementation until consuming 2 mg/kg/day through

complementary feeds or weaned to iron fortified formula. Screening for iron deficiency and iron deficiency anemia at 6 months with hemoglobin, serum ferritin, and C-reactive protein or reticulocyte hemoglobin is recommended (Berglund, Westrup & Domellöf, 2010).

- c. The late preterm infant should have weekly weight checks until 40 weeks postconceptual age or until he or she is thriving. Weight gain should average 20–30 g/day, and length and head circumference should each increase by an average of 0.5 cm/week (Grunmer-Strawn, Reinold, & Krebs, 2010). (III)

Definitions:

Levels of Evidence

I Evidence obtained from at least one properly randomized controlled trial.

II-1 Evidence obtained from well-designed controlled trials without randomization.

II-2 Evidence obtained from well-designed cohort or case-control analytic studies, preferably from more than one center or research group.

II-3 Evidence obtained from multiple time series with or without the intervention. Dramatic results in uncontrolled experiments (such as the results of the introduction of penicillin treatment in the 1940s) could also be regarded as this type of evidence.

III Opinions of respected authorities, based on clinical experience, descriptive studies and case reports; or reports of expert committees.

Clinical Algorithm(s)

None provided

Scope

Disease/Condition(s)

Infant health/nutrition

Guideline Category

Evaluation

Management

Prevention

Risk Assessment

Treatment

Clinical Specialty

Family Practice

Nursing

Nutrition

Obstetrics and Gynecology

Pediatrics

Intended Users

Advanced Practice Nurses

Allied Health Personnel

Nurses

Physician Assistants

Physicians

Guideline Objective(s)

- To promote, support, and sustain breastfeeding in the late preterm infant
- To maintain optimal health of the infant and mother
- To allow the late preterm infant to breastfeed and/or breastmilk feed to the greatest extent possible
- To heighten awareness of difficulties that late preterm infants and their mothers may experience with breastfeeding
- To offer strategies to anticipate, identify promptly, and manage breastfeeding problems that the late preterm infant and mother may experience in the inpatient and outpatient settings
- To prevent medical problems such as dehydration, hypoglycemia, hyperbilirubinemia, and failure to thrive in the late preterm infant
- To maintain awareness of mothers' needs, understanding of current plans, and ability to cope

Target Population

Late preterm infant (34^{0/7} to 36^{6/7} weeks gestation) infants and their mothers

Note: Infants born at 37^{0/7}–37^{6/7} weeks may be at risk for breastfeeding problems and associated risks, and, therefore, these guidelines may be applicable to these infants as well.

Interventions and Practices Considered

Evaluation/Risk Assessment

1. Inpatient care
 - Assessment/reassessment: gestational age and associated risk factors, breastfeeding
 - Evaluation of breastfeeding by lactation consultant or other certified health professional with expertise in lactation management
 - Monitoring of clinical status of infant: vital signs, weight, stool and urine output, milk transfer
 - Monitoring for frequently encountered problems: hypoglycemia, hyperbilirubinemia, dehydration, excessive weight loss, failure to thrive
 - Documenting of breastfeeding (LATCH score, Infant Breast-feeding Assessment Tool [IBFAT], Mother/Baby Assessment Tool)
 - Discharge planning (assessment of criteria for discharge readiness, feeding plan, follow-up appointment)
2. Outpatient care
 - Outpatient monitoring of mother and infant
 - Initial visit: outpatient office or home visit
 - Review of inpatient maternal and infant records, feeding history
 - Review of breastfeeding since discharge
 - Examination of infant (weight, alertness, hydration)
 - Observation of baby feeding at breast
 - Assessment of mother (breasts, emotional status)
 - Follow-up
 - Weekly weight checks
 - Monitoring for adequate growth

Management/Treatment

1. Inpatient care

- Written feeding plan
- Avoidance of separation of mother and infant
- Avoidance of thermal stress by using skin-to-skin (kangaroo) contact, double wrapping, incubator
- Breastfeeding on demand
- Communicating changes in feeding plan
- Breastfeeding education
- Supplemental feedings as indicated: supplemental nursing device at the breast, cup feeds, finger feeds, syringe feeds, or bottle
- Communicating discharge-feeding plan to outpatient pediatric care provider

2. Outpatient care

- Adjustment of feeding plan for babies not gaining weight well
- Evaluation of latch difficulties
- Management of jaundice
- Use of galactogogues in mothers with documented low breastmilk supply
- Vitamin D supplements
- Iron supplements

Major Outcomes Considered

- Adequate weight gain, growth, and normal biochemical indices in near-term infants
- Morbidity associated with medical problems of inadequate lactation such as dehydration, hypoglycemia, hyperbilirubinemia, and failure to thrive

Methodology

Methods Used to Collect/Select the Evidence

Searches of Electronic Databases

Description of Methods Used to Collect/Select the Evidence

An initial search of relevant published articles written in English in the past 20 years in the fields of medicine, psychiatry, psychology, and basic biological science is undertaken for a particular topic. Once the articles are gathered, the papers are evaluated for scientific accuracy and significance. For the June 2011 update, PubMed was searched for articles published between 1990 and September 2010. Reference lists from those articles were also searched.

Inclusion criteria included preterm infants in late preterm infant (LPI) age range for neurodevelopment outcomes, growth outcomes, hyperbilirubinemia and reviews of LPI or near term infants. Literature describing feeding and breastfeeding techniques for preterm, hypotonic infants and infants with feeding problems were included. A few articles with poor methodology were excluded.

Search terms included: late preterm, near term, kernicterus, hyperbilirubinemia, preterm breastfeeding, cup feeding, nipple shields, breastfeeding assessment, gestational age assessment, finger feeding, pumping breast milk, test weights, skin to skin, kangaroo care, iron deficiency, low birth weight, vitamin D and breastfeeding, supplementation and breastfeeding, late preterm and respiratory outcomes, late preterm and readmission, late preterm and developmental outcomes.

Number of Source Documents

Not stated

Methods Used to Assess the Quality and Strength of the Evidence

Expert Consensus (Committee)

Weighting According to a Rating Scheme (Scheme Given)

Rating Scheme for the Strength of the Evidence

Levels of Evidence

I Evidence obtained from at least one properly randomized controlled trial.

II-1 Evidence obtained from well-designed controlled trials without randomization.

II-2 Evidence obtained from well-designed cohort or case-control analytic studies, preferably from more than one center or research group.

II-3 Evidence obtained from multiple time series with or without the intervention. Dramatic results in uncontrolled experiments (such as the results of the introduction of penicillin treatment in the 1940s) could also be regarded as this type of evidence.

III Opinions of respected authorities, based on clinical experience, descriptive studies and case reports; or reports of expert committees.

Methods Used to Analyze the Evidence

Systematic Review

Description of the Methods Used to Analyze the Evidence

An expert panel is identified and appointed to develop a draft protocol using evidence based methodology. An annotated bibliography (literature review), including salient gaps in the literature, is submitted by the expert panel to the Protocol Committee.

Methods Used to Formulate the Recommendations

Expert Consensus

Description of Methods Used to Formulate the Recommendations

Not stated

Rating Scheme for the Strength of the Recommendations

Not applicable

Cost Analysis

A formal cost analysis was not performed and published cost analyses were not reviewed.

Method of Guideline Validation

External Peer Review

Internal Peer Review

Description of Method of Guideline Validation

The draft protocol is peer reviewed by individuals outside of contributing author/expert panel, including specific review for international applicability. The Protocol Committee's sub-group of international experts recommends appropriate international reviewers. The Chair and/or protocol resource person institutes and facilitates this process. Reviews are submitted to the committee Chair and resource person.

The contributing author/expert panel and/or designated members of protocol committee work to amend the protocol as needed.

The draft protocol is submitted to the Academy of Breastfeeding Medicine (ABM) Board for review and approval. Comments for revision will be accepted for three weeks following submission. The Chair, resource person and protocol contributor(s) amend the protocol as needed.

Following all revisions, the protocol has the final review by original contributor(s) to make final suggestions and ascertain whether to maintain contributing authorship.

The final protocol is submitted to the Board of Directors of ABM for approval. A two-thirds majority of Board members' positive vote is required for final approval.

Evidence Supporting the Recommendations

References Supporting the Recommendations

Academy of Breastfeeding Medicine Protocol Committee. ABM clinical protocol #22: guidelines for management of jaundice in the breastfeeding infant equal to or greater than 35 weeks' gestation. *Breastfeed Med*. 2010 Apr;5(2):87-93. [53 references] [PubMed](#)

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Type of Evidence Supporting the Recommendations

The type of supporting evidence is identified and graded for selected recommendations (see the "Major Recommendations" field).

Benefits/Harms of Implementing the Guideline Recommendations

Potential Benefits

- Promotion, support, and sustenance of breastfeeding in late preterm infant with maintenance of optimal health of the infant and mother
- Prevention of medical problems such as dehydration, hypoglycemia, hyperbilirubinemia, and failure to thrive in the late preterm infant

Potential Harms

Not stated

Qualifying Statements

Qualifying Statements

A central goal of the Academy of Breastfeeding Medicine is the development of clinical protocols for managing common medical problems that may impact breastfeeding success. These protocols serve only as guidelines for the care of breastfeeding mothers and infants and do not delineate an exclusive course of treatment or serve as standards of medical care. Variations in treatment may be appropriate according to the needs of an individual patient. These guidelines are not intended to be all-inclusive, but to provide a basic framework for physician education regarding breastfeeding.

Implementation of the Guideline

Description of Implementation Strategy

An implementation strategy was not provided.

Institute of Medicine (IOM) National Healthcare Quality Report Categories

IOM Care Need

Staying Healthy

IOM Domain

Effectiveness

Patient-centeredness

Identifying Information and Availability

Bibliographic Source(s)

Academy of Breastfeeding Medicine. ABM clinical protocol #10: breastfeeding the late preterm infant (34(0/7) to 36(6/7) weeks gestation). *Breastfeed Med*. 2011 Jun;6(3):151-6. [53 references] [PubMed](#)

Adaptation

Not applicable: The guideline was not adapted from another source.

Date Released

2004 (revised 2011 Jun)

Guideline Developer(s)

Academy of Breastfeeding Medicine - Professional Association

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Academy of Breastfeeding Medicine

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Guideline Committee

Academy of Breastfeeding Medicine Protocol Committee

Composition of Group That Authored the Guideline

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Financial Disclosures/Conflicts of Interest

Not stated

Guideline Status

This is the current release of the guideline.

This guideline updates a previous version: Academy of Breastfeeding Medicine. Breastfeeding the near-term infant (35 to 37 weeks gestation). New Rochelle (NY): Academy of Breastfeeding Medicine; 2004 Aug 22. 6 p.

Guideline Availability

Electronic copies: Available in Portable Document Format (PDF) from the [Academy of Breastfeeding Medicine Web site](#)

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Print copies: Available from the Academy of Breastfeeding Medicine, 140 Huguenot Street, 3rd floor, New Rochelle, New York 10801.

Availability of Companion Documents

The following is available:

- Procedure for protocol development and approval. Academy of Breastfeeding Medicine. 2011 Mar. 2 p. Available from the [Academy of Breastfeeding Medicine Web site](#) .

Print copies: Available from the Academy of Breastfeeding Medicine, 140 Huguenot Street, 3rd floor, New Rochelle, New York 10801.

Patient Resources

None available

NGC Status

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